

Humiliation

Is not Just About the Intent to Shame and Degrade

Some Facets of the Psychotherapy of
Trauma Related to Humiliation

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ACUTE SHAME CAN BE UNDERSTOOD AS LEADING TO THE DEVELOPMENT OF enduring shame-laden mental states (Chefetz, 2020). Early experiences of repetitive shame lead to chronic shame that is dyed in the wool from which the fabric of an unsuspecting child's mental life is spun, a caul of shame created so early that it has the subjective experience of a given. It is upon that kind of shame-laden fabric that the imprinting of humiliation experience looks different than what we can see printed on the emotional clothing of those with even a modicum of self-esteem.

With the presence of self-esteem, a person becomes angry at efforts to humiliate them because they feel undeserving of such treatment. When shame is implicit in the very structure of an already wounded sense of self, then humiliation may be met with acceptance, resignation, confusion, fears of annihilation, paralysis, feelings of powerlessness, depersonalization, dissociative state change (switching), unconscious or conscious rage, self-destructive behavior, or suicidality, and especially the feeling of being permanently stained, damaged, or defective, among other responses. When humiliation finds an agar to its liking—and even after only a short incubation period—feeling unlovable, defective, or bad becomes an ongoing subjective trifecta from hell. Add to this the all-too-common bullying and ridicule of childhood, or the misfortune of having any manner of physical deformity, and the ten-

dency of peers to mock and point is unerringly wounding at the deepest levels. Righteous indignation is often not on the list of reactions to humiliation in the context of chronic complex post-traumatic stress disorder (PTSD), or its more extreme cousin, dissociative identity disorder (DID).

Humiliation deserves a close look lest we lump it too quickly with shame experience and lose track of its compelling explanatory power in the treatment of trauma. However, humiliation is indeed part of the shame spectrum of emotion, and that is a good place to start its exploration. A moment, though, might be well spent in considering how we might most beneficially think about feelings in a clinical context, especially those as complicated as the spectrum associated with shame.

Some Preliminary Thoughts About a Theory of Feelings: An Affect Theory

I need not reference the reality that many clinicians use the words “affect,” “feeling,” and “emotion” interchangeably in clinical discourse. However, what’s routine may be a disadvantage. The vicissitudes of shame and humiliation, and the hot blush of recognition, require that somatosensory experience be included as an essential component of psychotherapeutic inquiry alongside psychodynamic and cognitive processes. There is a somatic imperative, a requirement to consider the body as part of the mind, the holder of inarticulate subsymbolic (Bucci & Maskit, 2007) contexts for lived moments when language fails in the experience of trauma (Rauch et al., 1996, 2003; Shin et al., 1997, 2005, 2006).

Feelings have a physiological basis. They are literally a physical experience, a feeling, an embodied sensing. They are described by words that assign a lexicon of parsed meaning through words signifying emotion. A more elaborate discussion of this issue is elsewhere (Chefet, 2015). Let’s consider how thinking this way adds to the vitality of a clinical discourse. The following is a statement of my clinical experience, and the interpretation of such relies heavily on understandings gleaned from the work of others who have studied affect for a lifetime and to whom I remain indebted (Lane & Nadel, 2000; Lane et al., 1990; Ledoux, 1996, 2012; LeDoux & Pine, 2016; Panksepp, 1998, 2004; Panksepp & Biven, 2012; Tomkins, 1962, 1963, 1982).

I prefer to use the word “affect” to describe the physiology that underlies the production of what eventually rises into consciousness as an embodied sensing; a feeling, something I feel in my body as a result of physiological

responses to the mind's internal and external environment. These unconscious affective processes may be described by biofeedback-like measurable changes in skin conductance and may be associated with sympathetic nervous system outflow, for example, the flow of blood through small blood vessels that create the red flush in the skin of the upper chest or face associated with shame, or the release of adrenalin in response to fear that provokes muscle tension. These processes create a kind of somatic summation-vector that lead to this embodied sensing, a feeling. These physiological changes tend to be outside awareness.

My clinical observation in hypochondriasis reveals there is a hypersensitivity to affectivity and an inability to know the meaning of somatic experience. This leaves the feeler nearly terrified, often frantic, about what's happening to their body. In the clinically opposite realm of depersonalization, bodily sensation may be absent. The mind of the depersonalized person may be highly reactive to the emotion-laden scene that the non-depersonalized individual would recognize as charged, but with depersonalization the cognitive processes associated with knowing a feeling are slowed, blunted, or delayed to the point of sensing something is "off," if anything is sensed at all, without knowing what or why (Sierra et al., 2002).

Kelly (2009) opined that Tomkins's affect psychology solved the problem of stimulus confusion by sorting experience through unconscious affect. An affect was stimulated, and then experience became known. Clinically, my posttraumatic patients come to me mostly with all manner of feeling capacities decreased or absent (some do come emotionally flooded) (Lanius et al., 2010). This is secondary to dissociative numbing, redirected through dissociatively activated psychodynamic processes like denial, disavowal, and undoing, or unconsciously enacted without awareness of the meaning of their behavior (Ryle, 1999). Treatment moves people toward consciousness for emotion. However, emotional pain is a deterrent. In this context it is important to note that our somatizing patients have a neurobiological burden of a confusion between pain affect and pain sensation. Pain affect may encode in brain organs like the anterior cingulate cortex that are associated with consciousness, but not the somatosensory cortex associated with physical sensation (Rainville et al., 1997). Anxiety about pain increases pain perception and activates hippocampal networks (Ploghaus et al., 1999, 2001). Emotional pain must be resolved in order, at least in part, to reduce suicidality (Levinger et al., 2015), but beyond that, in order to tolerate the reconstruction of an accurate trauma narrative, without which healing does not occur.

Faces communicate states of feeling, and our brain is wired interactively to know what our face is showing as well as what other people's faces are showing (Gallese et al., 2007; Pizzagalli et al., 2002). In children, disgust faces may signal anger (Widen & Russell, 2010). In people with isolated self-states, as in DID, emotional reaction may be different for one self-state than for another (Schlumpf et al., 2013). The conveyance of emotion through facial expression may be crucial to emotional development (Beebe et al., 2016), and form at least part of the basis for right-brain-to-right-brain communication between mother and child (Schore & Schore, 2008). The bottom line here is that if a therapist can't see the client's face, or the therapist is relatively bereft of facial expression, emotional communication may suffer a great deal. (This is magnified in the culture of online psychotherapy that is part of the response to the SARS-CoV-2 pandemic. It requires, in my opinion, an additional effort on the part of the clinician not only to be conscious of this parameter, but to significantly add their own physical indicators of affective life through facial expression and especially the prosody of their voice. We do well to put the hypnotic-like qualities of good communication to work.) It is no wonder, then, that states of shame or humiliation often involve the reaction of hiding one's face. In a broader sense—closer to the feeling of what happens in shame-laden trauma—there may be an effort to hide one's mind, not only from others, but from oneself.

No clinician reading these words would fail to recognize the familiarity of the experience of hearing one of their patients describe a raw empty feeling in their belly; a kind of nearly nauseous weight of indescribable presence, associated with feeling weighed down, heavy, as if unable to find any energy in their body for no particular reason. The relief such a person can experience if the bodily feeling is correctly named, such as sadness, and the subsequent connection of the narrative of their life to this named emotion occurs, is a wonder to behold. Naming feelings is important, and if feelings are a kind of personal and interpersonal radar, then knowing feeling is essential for living a conscious life.

Physiological precursors and embodied sensings refer to affect and feelings, respectively. Emotion words have a special place in language. They are symbolized relational shortcuts that convey complex scripts (Tomkins, 1995) succinctly. The nuances of experience are perhaps best described by the poets, and yet us mere mortals must still find a way to talk with each other about our feelings. If we are not taught the words for emotions, then we are at a real disadvantage in life.

Not having words for feelings, the concept of alexithymia (Taylor, 2000), represents a body of research exploring what has been found to be a trait in people. In my clinical practice, however, a relative alexithymia is closer to the norm in some people: They often start treatment unable to express both thoughts and feelings. But after an emotion-focused approach to their psychotherapy (Greenberg, 2004; Johnson et al., 1999; Paivio & Nieuwenhuis, 2001), their use of emotion words and their experience of being alive in their body has often increased dramatically. In my practice, alexithymia is related to state rather than trait. In parallel to this is the concept of alexisomia, not having words for sensations (Ogden et al., 2006). Providing a menu of language for a patient that helps them describe an embodied sensing in more clear terms can assist in the process of moving toward symbolization through the use of words for specific emotions.

We have emotional memory, even if we don't always have great access to it (e.g., depersonalization), and we constantly make nonconscious associations to our past experiences, both at the narrative level and the psychodynamic. My clinical approach benefits from a mostly affective neuroscience perspective for what Panksepp (1998; Panksepp & Biven, 2012) has called emotional feelings and their subcortical correlates, as well as an appreciation of the sophisticated higher-order appraisal processes described by cognitive neuroscience (Lane & Nadel, 2000). Once a library of emotional experiences is achieved, higher-order appraisals occur quickly and routinely via associative processes. These appraisal processes may influence how a person interprets consciousness for the subcortical activation of pathways associated with a particular felt experience. Dissociative processes undermine these important contextualizers of experience and may make meaning indecipherable. A clinical perspective that makes use of the clinician's consciousness for somatosensory dimensions of experience is *a priori* an affective neuroscience approach that benefits from an appreciation of the connection of affective dimensions of experience with subcortical structures (Lamm & Singer, 2010; Ledoux, 1996; LeDoux & Pine, 2016; Rauch et al., 1996; Shin & Liberzon, 2010).

One particular advantage in thinking about affects as a kind of proto-sensation, and feelings as embodied sensings, is related to special trauma treatment techniques and the use of hypnotic protocols (Spiegel & Spiegel, 1978; Watkins, 1971) as well as eye movement desensitization and reprocessing (EMDR) (Forgash & Knipe, 2012; Shapiro, 1995). The uses of bodily states, embodied sensings, and feelings as an entry point (target) for the clinical inquiry is a powerful nonverbal approach. Focusing also makes use of

this affective reality (Gendlin, 1978). Traumatic experience is often without words. The creation of new narrative—reconstruction of the trauma scene—is a central part of treatment. It's nice to have some theory to undergird this effort.

The Shame Spectrum of Emotion

Shame-related emotion pivots on the experience of feeling in some way devalued or as generating action toward devaluing another. Guilt must be considered here because there are numerous clinically salient patterns of mixed guilt and shame (Tangney & Dearing, 2003; Tangney et al., 1996). However, guilt is less about feeling devalued and more about knowing that you have done something wrong and regretting it while maintaining self-esteem. Embarrassment, shame, humiliation, and mortification are each about loss of value, while contempt, disgust, dismissal (noticing a “stinker”; Tomkins & McCarter, 1995), loathing, ridicule, and bullying are about efforts to devalue another. Each of these feelings exposes core narcissistic vulnerability or injury that may generate fears of annihilation or compensatory grandiosity (Kohut, 2009; Wolf, 1988). The inward-facing experience of shame is more attachment oriented, seeking relatedness, while the outward-facing attack of contempt is about establishing a competitive ranking organization or domination-submission, and seeks to maintain distance (Gilbert, 2005). Elsewhere I have described the simultaneous activation of attachment and competitive-ranking motivational systems as an “attackment” experience (Chefet, 2015, 2018); that is, creating an experience of confused and unconsciously simultaneous efforts at tenacious connection and desperate distancing. There is an implicit sense of needing to be close to be safe while also feeling a desperation to distance in order to be safe. Dissociative processes make this kind of constellation more intelligible as the product of relatively isolated self-states with conflicting needs and fears.

Shame-organized constellations of experience are reminiscent of Nathanson's (1992) compass of shame. Set about the points of a compass, the east-west dimension is about an attack response when feelings of shame suddenly emerge into awareness, attack self, or attack other. This bypasses feelings of helplessness and loss of efficacy associated with shame through a compensatory effort to restore agency with action. The north-south dimension is about a more passive response to shame—avoid or withdraw. Agency is restored in this case by taking charge and removing the incitement from face-to-face

awareness, whether that is with a person or a physical location. An impulsively canceled psychotherapy session after a disruption in the therapeutic alliance is an example. Each of these dimensions describes a typical pattern of reactivity when suddenly feeling shame. The visibility of unexpected attacks or avoidance/withdrawal in psychotherapy predicts the potential utility of Nathanson's compass and gentle probing to locate possible shame experience at the source of this kind of behavior. At a minimum, sudden attack of self/other or avoidance/withdrawal in a treatment ought to raise consciousness in a clinician that a shame experience may have occurred.

I find it helpful to think of the sequence of embarrassment, shame, humiliation, and mortification as one of increasing intensity. Embarrassment is more about a kind of self-consciousness of personal lack or error than an acute sense of feeling devalued, as occurs in acute shame (Trumbull, 2003). Chronic shame is a much more deeply painful experience and is regularly associated with complex PTSD as well as the dissociative disorders. Chronic shame is less about single or multiple occurrences of shame and more about shame that is resident in the core construction of the sense of self, where the nearly amniotic feeling of the origin of shame takes root. Shame-spectrum experience is always relational, a feeling of disintegration of self in relation to a dysregulated other (DeYoung, 2015). Chronic shame often occupies a place of what I have called omnipotent badness, a badness that explains what happens to me in the universe (Chefet, 2000): I am bad, and bad things happen to me because I deserve them. If anybody is to be hurt, it ought to be me since I deserve nothing better and am unlovable. I deserve to be dead. Mortification refers to the sense of needing to suffer through ascetic or penitential means in order to ameliorate the wish to sin. In less spiritual or religious contexts, the use of the word conjures a feeling that "I was so ashamed I could have died. I was mortified." This intense shame experience and the sense of a need for physical punishment in response is often part of a chronic shame or humiliation experience. Or, in other words, "what happened is so awful that my interest in living is blocked" (Kelly, 2009, p. 21).

The reader who has studied shame and humiliation experience knows how challenging it can be to separate the two. The writer's intent is to highlight those aspects of humiliation experience that may distinguish it from shame. The stuck-in-molasses-like experience of working with chronic shame and humiliation may require an exquisitely detailed exploration of these experiences in order to tease them out from the mind-numbing blankness that often obscures exploration of the shame spectrum of experience. Using highly

specific language synonymous with humiliation experience allows exhuming very difficult areas of experience not otherwise accessible with only the language of shame.

Shame Experience

In the study of shame, all paths lead to two intellectual streams that eventually join and create a formidable river—the works of Sylvan Tomkins and Helen Block Lewis. Tomkins's work is extraordinary in its detail and depth (Tomkins, 1962, 1963, 1982; Tomkins & Karon, 1962), among others (Lansky, 1992; Lewis, 1992; Miller, 1985; Morrison, 1989; Nathanson, 1992; Tangney & Dearing, 2003). I have found that reading Tomkins through the keen sight of several of his interpreters is rewarding (Demos, 1995; Kaufman, 2004; Kelly, 2009). Tomkins's notion of what he called the innate affect of shame-humiliation, as described by Kelly, was that this affect motivates us to take action toward the satisfaction of enjoyment when we are suddenly deprived of interesting and enjoyable things. Kelly tries to make clear that shame occurs when our interest-excitement is blocked, and we don't want it to be so. In his discussion, he emphasizes that shame-humiliation would not occur if no interest-excitement was activated. (In Tomkins's nosology, interest-excitement is one of the primary innate affects, while shame-humiliation is an accessory affect, an affect modifier that acts upon a primary positive innate affect to downregulate it.)

I find the scientific-sounding references to stimulus, signals, and so on less congenial to my psychodynamic orientation than I would prefer. But there is a valuable punch line for the reader who stays with Tomkins's ideas: shame is inherently relational in Tomkins's formulation, too, because the disruption of interest-excitement creates a longing to reconnect and establish the positive connection that was lost (Demos, 2019). That's a big deal, and I believe it's true of humiliation experience, but in a different way that relates more to the use of power and the dynamics of domination and submission. This motivational system shift tends to make meaning flow toward the realm of humiliation experience and away from contexts of shame, a movement from attachment motivations of safety in the presence of another toward competitive-ranking motivations (domination-submission), safety in a hierarchy of power.

The clinical wisdom of Helen Block Lewis has always delighted me. "Shame is contagious. It is so painful that the witness to it ordinarily looks

the other way. Contemporary psychoanalysts are no exception to this tendency. . . . Unanalyzed shame may be playing a part in 'negative therapeutic reactions' before assigning patients to an ominous 'borderline' or 'narcissistic' category" (Lewis, 1987, p. 2). Beyond this reason for shame's neglect in contemporary psychiatry, Lewis notes, "An ethical system based on the premise that human nature is evil or aggressive will emphasize guilt as its major control, whereas an ethical system that includes human sociability as a 'given' will also emphasize the shame (in one's own eyes) of losing the love of the 'other.'" This dovetails nicely with Tomkins's more scientific statements about shame as an affect modifier that activates when interest-excitement is blocked and relatedness is sought as a repair. Having reviewed some aspects of shame experience, let's look at humiliation and then see to what extent it is distinct from shame.

Humiliation Experience

Humiliation "is a relational form of human behavior stemming from interpersonal dynamics that cannot be adequately explained by individualistic, intrapsychic theories" (Hartling & Luchetta, 1999, p. 260). In shame, power dynamics may be relatively invisible. In humiliation they are right out front. In fact, in looking at the scene of international relations, there is reasonable speculation that humiliation may be considered the nuclear bomb of emotions (Hartling et al., 2013). This goes beyond the coherent arguments offered by others regarding bypassed and unacknowledged shame as a profound contributor to social violence (Scheff & Retzinger, 2001) and speaks to ongoing conflicts that have been well explored (Lacey, 2011). Bypassed shame occurs when, for example, hyperv verbal activity is used to deflect and cover over experiencing shame (Lewis, 1987). Unacknowledged shame is another of Lewis's concepts that predicts the buildup of resentment and retaliatory fantasies, things that melt away when shaming experiences are acknowledged by perpetrators and apology is offered as an olive branch toward the restoration of dignity for all (Hicks & Tutu, 2011). Humiliation is more about a wish to damage or destroy a person, to render them nonthreatening, not just to tell them they are bad or unlovable.

Social-psychological views of humiliation are importantly informative in this regard (Torres & Bergner, 2010). Claims of social status inherent in a person's life may be accepted or rejected. It is the rejection of these claims that create humiliation and an ability to degrade an individual who is publicly

exposed, for example, in a courtroom. Powerless rage, hopelessness, helplessness, and suicide are potential outcomes of a public humiliation. Motivation in life may be preempted by humiliation experience, eclipsing all other motivations. There may also be a loss of status as an appraiser of reality, or a loss of status to claim basic human rights that are associated with a sense of worthlessness and profound loss of self-esteem also typical of shame.

Thus, humiliation can also be seen as less of an intrapsychic event and more of an act that occurs in the world (Leask, 2013). For Leask,

The impact of the act of humiliation will vary, in part because of the resilience built in by successful early relationships and in part because of strategies of resistance (which themselves may owe much to such early relationships). I also suggest that recognising the specific nature of humiliation has implications for the relationship between the therapist and the patient" (2013, p. 130).

He further recognizes that humiliation dynamics include unconscious factors that have led the patient to become repeatedly entangled in relationships replete with humiliation experience. Leask considers humiliation an action that makes humiliation less a matter of the victim feeling humiliated but more about being humiliated, something done to another unjustly and with apparent impunity, an active exercise of power. This act consistently demonstrates

stripping of status; rejection or exclusion; unpredictability or arbitrariness; and a personal sense of injustice matched by the lack of any remedy for the injustice suffered. . . . Humiliation leads to a strong sense that one has been wronged, while shame involves a sense that one has done wrong and is diminished in one's own eyes or in the eyes of others. (Leask, 2013)

I'm glad that Leask identified the wielding of power in the experience of humiliation. My patients often fully recognize their sense of powerlessness in the face of feeling humiliated as well as shamed. Not only is there a loss of power as a hallmark of humiliation, but there is a profound fear of challenging the power of the perpetrator lest the act of humiliation be surpassed by annihilation. Not only does this crush a protest, but it smacks down and suppresses the rage in the victim that accompanies the experience of shame or humiliation. This effectively welds rage to shame or humiliation (Chefet, 2015; Lewis, 1987). When this happens, going near a shame or humiliation

experience in psychotherapy often quickly exhumes formerly buried rage that can overwhelm self-regulatory capacities and result in self-harm or harm to others. This is especially the case if the rage is isolated in a self-state typical of DID.

For example, Rachel, whom I have written about before (Chefet, 2009), became actively suicidal for three harrowing weeks after the first time I speculated she might feel some anger toward her mother. Her whole internal system of some 27 self-states was organized so as to ensure that she would not be in conflict with her mother, on any count, and that nobody might even know she was anything other than aligned with her mother. While her experience of sadistic abuse from an outside male perpetrator, Mr. X, was profound, it was the relentless out-of-tune adjustment of reality that her mother insisted upon that was most profoundly damaging for Rachel.

Inevitably, as she went further and further in treatment toward full embodiment, no depersonalization, and orienting herself to living in 2020 rather than being stuck in a trauma-laden past, she felt threatened by the changes and dug in her heels. She felt herself to be at risk of being humiliated and controlled by her mother in 2020. In this place, Rachel professed to have no mind, no wants, no needs, no self, and did not know what it meant when people said they liked her. She was not allowed to accrue any value, nor was she allowed by her internal system of states to do anything that asserted she had the skills to live in the world. If this self-conception was challenged, rage of suicidal proportion was unleashed. If she did not remain humiliated and incapable of making decisions to buy food, clothing, and so on, then she feared retaliation by her mother. She had become the chief humiliator of herself, a repetition of the experience with her mother. Here, the sense of the mother of her childhood still somehow being present in her mind was a tenaciously persistent experience, only slowly giving way toward the reality that her mother had done some growing and was no longer the same as the mother of childhood. But the longevity of this perception was enough to still terrify her and leave her entrenched in self-reinforcing humiliation experience as she failed, day after day, to live a life. Rachel was always blocked by self-states guarding the way to self-actualization. She lived in despair, feeling defective, unworthy of existence, a toxic brew of shame and humiliation slathered with self-protective rage. Her repetitive rage and humiliation prevented her from growth lest she lose the narrative of nearly her entire life and experience the sadness of decades of marginal living and untold losses.

The extent to which a humiliator exercises the intent to shame, degrade,

denigrate, demean, belittle, and annihilate the efficacy and esteem of another human being is a statement of the enormity of the impact of humiliation: an effort to destroy the humanity, the dignity, of another. It is an effort to damage and permanently disable, to destroy a felt threat to the humiliator, or to render the target of humiliation feeble as a way to assure the humiliator of their superiority and safety. This kind of act creates the experience of losing trust in the world (Leask, 2013). It creates a realization in the mind of the target of humiliation that nobody is going to rescue them; "nobody is coming." It's also true that because the humiliator's woes take origin in their own mind, the ghost from their very own nursery holding retaliatory sway over their adult personality, repetitions of efforts to humiliate regularly fail to reduce anxiety for more than a short period of time. As anxiety rises, acts that demonstrate domination through humiliation become more necessary, more insistent. This describes the scene in some families, some communities, and some nations as the fear of humiliation (Rothstein, 1984) infects in ways just as subtle as SARS-CoV-2, and leaves damage for years to come. It is terrifying when a head of state becomes the humiliator-in-chief. Even a donkey knows that, as the following reveals.

Yann Martel (2010) speaks of this in his chilling play within a novel, written by a taxidermist, the story of a donkey, Beatrice, and a monkey, Virgil, caught up in the extremity of Nazi Germany.*

BEATRICE: I never did tell you what happened to me, did I?

VIRGIL: What? When?

BEATRICE: When they arrested me.

VIRGIL: [*uneasy*] No, you didn't. I never asked.

BEATRICE: Would you like to hear about it?

VIRGIL: Only if you want me to.

BEATRICE: I should tell one person at least, so that the experience doesn't vanish without having been put into words. And who else but you?

[Pause.]

BEATRICE: I remember the first slap, just as I was being brought in. Already then, something was lost forever, a basic trust. If there's an exquisite collection of Meissen porcelain and a man takes a cup and deliberately drops

* Martel may be best known for his earlier novel, *The Life of Pi*.

it to the floor, shattering it, why wouldn't he then proceed to break everything else? What difference does it make, cup or tureen, once a man has made clear his disregard for porcelain? With that first blow, something akin to porcelain shattered in me. It was a hard slap, forceful yet casual, given for no reason, before I had even identified myself. If they would do that to me, why wouldn't they do worse? Indeed, how could they stop themselves? A single blow is a dot, meaningless. It's a line that is wanted, a connection between the dots that will give purpose and direction. One blow demands a second and then a third and onwards. (pp. 174–175)

The horror of Beatrice's captivity had just begun. There is much more, but for our purposes here to elaborate further would be gratuitous. What I can tell you is that in the psychotherapy of the person who brought this novel to my attention, we have referenced this section of the book numerous times as an exemplar of their childhood experience (not simply the part of Beatrice's story you have heard, but the part you'll have to find for yourself). It is too much to bear, and to be alone with the story, never to have been heard by another, as Beatrice noted, would be an affront, as if it had never happened, a kind of dissociative solution. Humiliation may create an experience of loss of trust in the world, nations, institutions, and, most importantly, people. To speak in psychotherapy of humiliation requires an extraordinary leap of trust, a tentative faith in the potential witness. I can say with authority that if a person has been betrayed and humiliated by a previous therapist, then the work in treatment is exponentially more difficult. Likewise, a betrayal or humiliation of one of my patients in treatment may fully test the relationship as no other event might.

Chronic shame often leaves a person with an omnipotent sense of badness (Chefet, 2000), a central organizer of beliefs about the self that explains why people shame and dismiss. This is the badness that explains the reasons underlying the knowing one is unlovable. In humiliation, the experience is of being deeply damaged and becoming inherently defective. The distinction is significant. To be unlovable is a condition of the heart; it's possible to secretly hold to an inarticulate hope of being loved, one day. To be humiliated and become defective is to be without the possibility of redemption, an even more hopeless position. In the language of Tomkins, it is to become a "stinker" and to see on the faces of those around you a sneering contempt with an upturned nose (a feeling aptly named "dis smell"; Tomkins & McCarter, 1995).

Just the reality of having a trauma and then being unable to resolve the

posttraumatic experience creates shame and humiliation. The stigma of mental illness is already upon a person with a significant loss of function due to a psychological problem. Shame is ubiquitous. When being judged by an outside other, humiliation experience is cemented in place. Moreover, when there is an internal harsh superego to which classical psychoanalytic theory speaks, no outside agent need speak up. There is a ready-made mechanism for an inside job fomenting humiliation experience. This is spelled out elsewhere (Chefet, 2015) and is based upon mechanisms described earlier in psychoanalytic theorizing whereby part of the ego is taken as an object (Freud, 1917). A more recent example is in a discussion of the severe neuroses (Wurmser, 2000). Each of these earlier works is consistent with a multiple self-state psychology; a ubiquitous finding when chronic shame and humiliation have taken root. In the language of the treatment of DID, these states have been dubbed “abuser-protector” states. The use of intrapersonal (self-state to self-state) and interpersonal self-regulation strategies based upon actions and experiences that evoke dissociative detachment and numb calm often instigates the ignition of self-harming activities or harm to others in a sad reenactment of abuse (Chefet, 2017).

Humiliation Experience in Psychotherapy

The early hours of the morning, often between 3:30 and 5:00 a.m., seem to be the time my mind often chooses to present me with preoccupying thoughts and feelings related to shame, humiliation, seemingly unresolvable conflict in my life and especially in my casework, my work with the people who hire me and then become my patients, the ones who suffer (according to the roots of the word). It is in this sleepy and then suddenly alert crucible of malleable and heart-pounding perception that some work often tries to happen in my mind. It feels like it intrudes without apparent plan or insight, just the rawness of me emerging into the unguarded, too-early morning.

One morning my consciousness blossomed with thoughts of a treatment gone awry, unwieldy as it nearly always had been, but more so, much more so, recently. There was the feeling of the inevitability of its failure, my failure, to untangle the mess. Embroiling, immobilizing, self-destructing, contemptuous, loathing, fearing, shaming, guilt, and humiliating experience seemed to swarm and swallow up all my efforts. As has been my habit in describing complex PTSD and DID, in moments like this we do not find ourselves in the paw of the lion, but in the giant maw leading to the belly of the whale—

trapped, no escape, marooned, undone, depleted, and unworthy (Chefet, 2020). Good morning to you, too.

It is challenging for me to pay attention to humiliation experience. It is an acidic, nauseous wave of crushing pain and doubt about personal efficacy. It etches deep grooves in the once-intact images of self-esteem that become like shards of broken glass waiting in the tall grass for my bare feet to be reminded of what came before. The reader may find it useful to consider how these sensory experiences I am talking about are exactly the kinds of things that I attend to when working with a person who is bereft of narrative but overflowing with sensory impressions that render them inarticulate. While the language is somewhat poetic, the earlier section on affect theory is informative of the several places I might intervene to open up access to more internal experience. "Tell me about the nausea, please. That's right. Where do you feel it? Can you focus on that and tell me what comes to mind? If you were to use the nausea as a search term in Google, and then click Enter and search, what would pop up as the first several hits?" This is an informal and conversational way to focus attention on the associative potentials hidden at the surface of the patient's productions. Attention to the somatic stirrings makes a big difference.

If a therapist asked me what kinds of images were popping up, and I told them it was an image of my mother, then without asking me for any narrative content, I could be engaged on an imagistic level to create associative links to otherwise isolated (dissociatively organized) material. "Okay, Rich, you said you had an image of your mother, right? Yes, good. Can you focus on that image please? Can you imagine the image on a TV screen? Good. Can you put the TV into split image mode and put your mother over on one side, please? Which side is she on? Good. Right. Okay, now on the left side pull up any other image of your mother that comes to mind and tell me what you see when you are ready, please." Treating the image as a sensory target, the patient stays oriented to the original image while pulling numerous other mother images from the past. Each pulled image has associative links, emotional and cognitive, even if they are consciously unknown to Rich. Within a day or so, this review of images will produce a raft of associations. Be careful not to go overboard on this. Ten or 15 minutes of this is more than enough. This is similar to a technique I call "interior decorating," which is a review of a childhood home (Chefet, 2015). The associations come quickly after an initial delay of a day or so. Knowing that emotional life is divided up into affective and embodied sensing dimensions allows me to focus my efforts on

tugging on the associable aspects of otherwise blocked emotional experience. Working with shame and humiliation is often just like this. Working with the crumbs of emotional experience can be very rewarding.

There is frankly nothing poetic in the experiences my patients tell me about of the abject power plays of humiliators who laugh at their vulnerabilities, ridicule their helplessness, and smile knowingly when their victim has been successfully tricked, once again, into believing some falsehood hiding in a carefully tailored costume of truth-like creations. While the scene I'm describing here is more about carefully planned sadistic abuse, the cloth from which humiliation is cut has many different styles when crafted into clothing that constricts, undermines, and burdens as it's worn.

My preference is always to write about a case, and yet it happens that writing about another person's sense of humiliation and asking them to vet that for publication is simply over-the-top ill-advised. Further, nearly all my patients who have powerful humiliation histories have uniformly and preemptively asserted their wish that I not publish anything about their experiences of humiliation. I can accept that, and so that just leaves my own experience to write about.

A Countertransference Analysis of the Experience of Humiliation

After several months of watching myself make a series of errors in a treatment that my patient took some passionately outraged pains to point out to me in their astonished disbelief, I had a dream: "I was talking with a patient, and they were yelling at me about how I had betrayed and injured them, how what I had done was unforgivable, and that it had destroyed any possibility for them to continue treatment." * Still in my dream, but from another

* To my patients: In writing about my personal experience, something I feel is a necessity lest intensive psychotherapy for trauma treatment be a black box for the clinician's experience, I do recognize the risk that somebody might believe I am writing about my experience with one of you. I regret that possibility. I can only say that this experience is related to a time prior to 2010, and in a treatment that ended. I wish I could have had my current knowledge of myself and of treatment dynamics earlier in my career, at the time of this treatment and dream. This is an example of why I believe that essays like this one must see the light of day. Younger clinicians tell me how relieved they feel to know that senior people make mistakes and still are learning

vantage point in my mind, I noticed how upset I was, how miserable I felt. I had an odd sense of the truth in what was being said to me as well as a kind of bafflement about it that was expressed in a clear question, delivered to my struggling awareness, in a pleading tone with a feeling of astonishment, that emerged suddenly into my mind: "How did I become such a monster?" I woke up, heart pounding, upset, and I was also aware that in having asked the question I was calming down. The sun was not yet up. I was exhausted. I was not a happy camper.

It is humiliating to be found so lacking, so incompetent as to make repeated errors of a similar kind. It's also very curious, and I can say that now, with authority, some years later, all the while having worked on these kinds of issues. I'll not review those earlier treatment circumstances. However, in more recent times, the trajectory of other work prompted me to recall having my monster dream. I found my notes, and now can finally breathe some life and meaning into them. So, in the spirit of what Alice told me when we discussed whether or not my countertransference reactions should appear alongside the detailed discussion of enactment in her treatment (Chefet, 2015), I will write about what I've come to understand about myself in relation to countertransference humiliation.

Dorahy (2017) wrote that adherence to shame helps a person to avoid the realization of humiliation experience in that the perpetrator intended to wound and diminish a person. Building on that clarity is that humiliation experience is linked to a call to action, much as with anger, because humiliation holds the knowing of the enormity of the power differential between abuser and victim. If the victim risks feeling powerful, shows their proportional rage and resentment, what one astute patient called "enragement," they are at risk of preemptive retaliation from the sadistic abuser for not masochistically accepting the abuser's dominance. An interesting dynamic arises in this context: The failure to heed the call to action in the moment of humiliation can be experienced as shameful, and a powerful self-hatred can be generated that takes the place of the threat of retaliation. There is also forbidden retaliation if the victim knows the vulnerabilities of the perpetrator well, loves them, and knows that to ruthlessly attack the perpetrator is to weaken and potentially destroy the loved person. (It is complicated, and

even after so much learning has come before. Senior people knowingly smile and may offer a hug, virtual or otherwise, pandemically speaking.

it's at its most complicated when both perpetrator and victim have a mental construction with isolated self-states typical in both complex PTSD and the dissociative disorders. It is routine to discover that a perpetrator has the emotional footprint of DID.) The call to action is diverted and targets the weak and pathetic self who failed to respond to the provocation of humiliation. Self is attacked, rather than other, as per Nathanson's compass of shame. Thus, a vicious cycle of humiliation, enragement, shame, self-hatred, self-disgust, and self-attack (after which humiliation is often also experienced for failing to maintain safety) is entered and may be sustained, at great cost.

So when humiliation occurs for the therapist, and the patient drives it home with apparently appropriate outrage, then these dynamics are at risk of rising up in the therapist. Do I accept the proclamations of my patient regarding my incompetence? Do I make an assessment of the actual error I made and plead for a mitigating proportional response from the patient, downgrading the fact of my error to one of a lesser crime? Can I stop my internal berating for making the same error, again? What do I do with the self-disgust, the shame, the failure to maintain the consciousness that is a hallmark of the therapist providing good treatment? And how did this failure of self-monitoring occur? Why? Should I accept the consultant's assessment that the patient has gone overboard with their outrage when I know that I did make several errors?

At a second level of consultation on a different case but with similar dynamics I presented a case to my peer consultation group (a group of highly seasoned clinicians; some of us have been meeting together, monthly, since 1998 with the intent to discuss difficult casework). To say that we know each other's stuff is an understatement. It is a safe venue for case presentation. In having presented material about such a case and talking about feeling humiliated and ashamed, I was taken aback by the protests of one person about my disregard for my self-esteem: "You are a fine clinician. What are you talking about here? You are caught up in the countertransference. What is going on?" Those words stuck with me, luckily, and helped to alert me to my own inside job. Multiple consultations about difficult cases are a good thing. Nobody can tolerate doing this work alone. A clinician spouse is neither adequate to shore up the reeling clinician, nor ought they necessarily be burdened with the repetition of these miserable dynamics. The dining table and the bed are for the discourse of a marriage, not the analysis of relentless or obsessional preoccupations of a messy treatment. A word to the wise.

How Did I Become Such a Monster?

Countertransference incompetence (Chefet, 2000) is an occupational hazard for the clinician engaged in trauma treatment. While objective countertransference is attributable to the reaction any experienced clinician would have to the interaction with a patient and their story, it is the subjective countertransference where the particular idiosyncrasies of the clinician distort the perception, responses, and interpretation of the patient's story and behavior (Gorkin, 1987). In a similar vein, enactment takes root in the fertile soil of isolated mental content (as Freud [1909] pointed out regarding isolated affect, a dissociative process). Bromberg elegantly spelled this out over the years in his books (Bromberg, 1998, 2006, 2011) and numerous papers. Dissociative processes encumber both clinician and patient, depriving them of consciousness for feelings, thoughts, and meaning that leave them prone to action as the only way left to communicate what hurts. In this context, the clinician and patient together earn the right for the clinician's self-disclosure (Bromberg, 2006; Levenkron, 2006) of their ongoing emotional context in the enactment. This is in the service of that disclosure leading to the benefit of the patient on the road to resolving the enactment and achieving relatedness (Stern, 2010) and reflective awareness (Fonagy & Luyten, 2009). It was Bromberg who made the case for the requirement for self-disclosure in the untangling of scenes of enactment as part of working through. Disclosing the therapist's shame to the patient? Disclosing the therapist's humiliation to the patient? Would you? Could you?

For the child who longs to be seen, to be known, and most of all to be loved, the parent whose capacity to love is impaired is a potential disaster. The only kinds of interpretation a small child has for the emotional unresponsiveness of a parental figure (the best predictor of adult dissociation is the emotional unresponsiveness of the parent; Lyons-Ruth et al., 2006) is that the child is invisible, does not exist, is unworthy of love, and/or is unlovable. And if the child continues to press the parent for an emotional response and fails to receive it, there is a sense of shame over the failure to get such confirmation. It is also a humiliating experience as the apparently withheld response—perhaps noticed as withheld, or noticed in the contrasting emotional aliveness exchanged with others but not the child, is not only a disconfirmation of the child's existence and value (a shaming experience)—but is taken as proof by the child of their failure to hold value and to be found

defective, lacking status, importance, a humiliation. It's not just that the child is bad. It's that they are hopelessly beyond redemption.

In relation to my patient Rachel, who continues in treatment, I wrote (Chefet, 2009, 2015) about some of the vulnerabilities I incurred in relation to my family of origin. I know that I was loved as a child. I can also say that as a child I don't think I knew what that meant because of the errors in communication that accumulated in relationships, particularly with my mother, but also with my father. These errors in communication (Hennighausen & Lyons-Ruth, 2005; Liotti, 2011) predict dissociative responses in the child and may account significantly for Type D, disorganized/disoriented infant attachment styles. It's important to be aware that Type B, secure attachment, often occurs in tandem with Type D in a family unit. While I have believed for many years that my choice of becoming a psychiatrist was related to my childhood job of helping to stabilize my mother's affectivity (Miller, 1981) and then repeating the effort later in life in 50-minute sessions, I can also see how caregiving controlling behaviors might play a role in my choice of careers and some personal habits. What if those controlling behaviors were rebuffed? What if they were declared of no value?

It is in this context that I've come to appreciate that ubiquitous shaming experiences in childhood set me up for the feeling of having become a monster in my countertransference responses to clinical scenes ripe with humiliation and shame. The alien-self (Fonagy et al., 2003) concept quickly came to mind after having reviewed my monster dream. The child may organize an unconscious alien sense of self if their fantasy superpowers, for example, are not met with markedness (Gergely & Watson, 1996) by a playful father who delightedly runs from the son who yells, "I'm going to get you!" but is instead met by the father who takes the small child's assertion as a challenge and backhands him across the face: "You little shit! Who the hell do you think you are?!" It's as if the parent fears the child's powers, and the message to the child is that they are dangerous and need suppression. The dangerous child is interpellated and felt to be alien, but undeniably present.

I can see that in my family of origin I was overwhelmed and deeply shamed by the repetitive outbursts of my frustrated mother, who—unable to manage her own anxieties and also respond to the challenges of parenting a precocious child—turned to gross shaming as a solution to clear any threats to her stability and to establish her dominance. Having been conscious in adult contexts for this activity in my mother, I can still see with my mind's eye the sneer of contempt, as in "How could you be so stupid?" or "Who would

do such a thing?" or "You lousy rotten kid," in moments when she was not her usual loving self and lapsed into self-protective modes of living. I know that she was in part repeating what came at her from her own mother. An eminently controlling woman, very loving, and who would do anything for her children, my grandmother, as a child, had walked during nights across the Pale of Settlement out of Ukraine, through Macedonia, into Romania, and then by boat to Marseilles, before eventually coming to New York City by sea in the early 1900s. Oh, did I mention her having hidden in haystacks in the barns of accommodating farmers during the daytimes, while Cossacks plunged pitchforks into the stacks to find fleeing Jews? A multigenerational trauma history is at work here.

My father's background was basically the same Pale of Settlement exodus story for his parents, but his mother was the daughter of a revered rabbi—and had even been educated. Life in the United States was a humiliation for her, an enormous loss of status. My father's normal rebelliousness was met with callous rule making and physical enforcement. His early outbursts toward me were so shameful for him, I believe, that he resorted to having me write endless repetitive behavioral admonitions: "I will not hit my sister" was a typical one. I can still remember his fury when he found me writing the first 50 lines in a column of "I," followed by a column of "will," and so on. What child has not done this? On the other hand, I had already learned about the violence in him that he squashed and was reinforced by my mother's shaming. I could feel it in the way he steeled himself in holding back his rage as he instructed me on what he wanted me to do for punishment. This was, I imagine, confirmation of the alien-self construct in me.

My alien self has been the child who knows he is bad, shameful, defective, a lousy rotten kid, and was required to be nice to everybody, especially girls, and had to compensate for all this by being a good, good boy. I think of this as a tyranny of niceness. This was humorously revealed to me during my family practice residency, before I became a psychiatrist, when my attending physician was curious as to why I had misspelled one of the words (penis) I put on the blackboard at his request during a urology lecture. I had spelled it "penice." Be nice. (I was actually insistent that the textbook spelling of "penis" was in error, when I went to check it!) This is one of the better examples of a parapraxis that I've come across. But it also seems, in retrospect, to be about undoing my alien-self feelings of being bad. I could not tolerate any badness in me.

The downside of this kind of unconscious admonition, of course, as Alice

and I discovered, was that with my anger inhibited, there was a way in which I was not real in response to her provocations. I couldn't be angry. I was not allowed. Of course, I did know my anger, but as a clinician I also had the conviction that getting openly angry with my patients was not useful. So I was not angry with her in response to her obvious provocations. She was desperate for my anger, which I withheld, unconsciously, while trying to be the good therapist (Searles, 1967). Of course, the more I tried to be good, the sicker she got, not only because I needed to be the rescuing hero, but especially because I denied her emotional reality, a particularly devastating thing for somebody living dissociatively. The idea that I could know I was angry and hold it, study it, learn from it, and metabolize it was known to me. I thought I did that. But it turned out that anger and an admixture of shame-humiliation was a stealth intruder invisible on my radar. Alice and I eventually figured this out. She actually was the one who tipped me off. It moved the treatment along quite nicely, finally.

It is in this context that I can still recall the emotional particulars of the failed treatment some years ago. I had come to hate my patient. She had been challenging me up one side and down the other for months. This was not a new experience. I didn't realize, though, how far under my skin she had gotten. Under the rule of unconscious law and my requirement to be nice, I didn't have the emotional freedom to know of my hate, then, even though I know it now. (I had then not yet evolved to embrace the perspective about hate provided by Winnicott, which I will describe later.) In the immediate throes of the scene where I had lashed out at my patient, the physiological response to her calling me to task, a clear shaming and humiliating, were devastating for me. Furious with me, my patient got up in a rage and walked out. Fear gripped me and left my body feeling weak. I was nauseous. At times I tasted the metallic taste of anxiety that I had not tasted since my first year in college at the first set of final exams. (This is another place in a treatment where the affect theory section earlier in this essay would guide exploration via associations to embodied sensings.) I was livid with myself for having failed to properly monitor my words. I had lashed out in response to a challenge in an unguarded moment and was pointedly dismissive and humiliating in my remark. I believed my patient was right. I was a poor excuse for a therapist. I felt inconsolable. I slammed my fist on the arm of my chair. I had done the opposite of what I had dedicated my professional life to do: to help those who had been traumatized to heal. Now I was re-creating that trauma for this person. How could I have done that?

Hate is love rejected. It is an entangled, vexed, preoccupying engagement. If it lasts for a bit, then it creates a barrier to relatedness on the basis of the previous rejection of the offered love (Balint, 1952). Indifference is the opposite of both hate and love. Hate is tenacious. I had really tried hard to meet this person where they were. Why did they continually challenge me? It was as if I were asking myself: How could they not love me? Look how good I have tried to be! Don't they know it? How can they say these things about me?

If I were secretly, unconsciously, viewing myself as a monster, that might account for the painful difficulty of "wearing the attributions" (Lichtenberg et al., 1996) when they are imbued with humiliating qualities. My alien-self organization would be loath to acknowledge its activation—and especially to own feeling defective and incompetent because it would prove the worst fears within me. Yet to be in denial about this would leave me unable to know feeling humiliated, and mounting a protest, including the possibility and freedom to feel hate toward the person attacking me. Had I the freedom to try on the attribution without risking collapse of my fantasy of being a good boy, then I could have the freedom to speak rather than to experience flushing, tachycardia, and obsessive preoccupations. I might then be able to say: "What's it like that I humiliated you?" "What's it like having a therapist who is incompetent?" "What comes to mind or happens in your body when you consider how badly I've behaved and what I've said?" "There's a look on your face that seems like hatred. Am I reading that correctly? What's happening for you, right now?"

A piece of a potential solution to countertransference humiliation is the capacity to protest, privately, and to know hate for the patient and contain it. A protest might be consistent with humiliation involving a feeling that the shaming attack is undeserved. This then requires a kind of consciousness for processes related to shame and humiliation that breeds tolerance for these feelings, as well as having core feelings of being lovable and loved.

Let's circle back to definitions and see how they resonate now. What is humiliation? Four themes are noted in a summary review of the literature: (1) being lowered in the eyes of others: losing esteem, social status, or dignity; (2) to feel psychologically lowered by somebody else through an attack reflecting hostile intent, including ridicule or torture; (3) this lowering occurs in the eyes of an audience, in public; and (4) is the humiliation related to a theme of incompetence, or is it undeserved? The last element described is inconsistently present in the literature (Elison & Harter, 2007). Like the

writer, these authors group shame, embarrassment, guilt, and humiliation as members of a family of emotion with fuzzy borders: the shame family. Determining which member of the family is most prominent requires getting into the details of the experience. Of course, countertransference humiliation a priori assumes that what the clinician experiences in the relationship with the patient has at least some validity, or the patient wouldn't challenge the therapist in the first place. So it's the job of the clinician to determine the degree of validity—and to take the stance of wishing to learn from the experience. This learning is toward being both more knowledgeable about self—and to then be able to make use of that knowledge in the service of helping the patient to understand their own experience. It means that there needs to be a capacity to know and feel hate in response to efforts at humiliation. Again, it needs to be emphasized that this relies upon a solid sense of self-worth, relatedness, and the feeling of being loved and lovable as a bedrock felt knowing.

Countertransference Hate and Humiliation

Winnicott classified countertransference phenomena in three ways: (1) abnormality in feelings that are under repression in the analyst and requiring more analysis, (2) personal qualities in the analyst that provide the positive setting for analytic work and make the work different in quality from that of any other analyst, and (3) the analyst's love and hate in reaction to the actual personality and behavior of the patient, based upon objective observation. He suggests that "if an analyst is to analyze psychotics or anti-socials he must be able to be so thoroughly aware of the counter-transference that he can sort out and study his *objective* reactions to the patient. These will include hate" (Winnicott, 1949). Later, "in the ordinary analysis the analyst has no difficulty with the management of his own hate. This hate remains latent." For Winnicott, it is likened to the hate a nursing mother feels toward the infant who bites her tender breast. The growing infant's behavior is hated, not the infant's essence.

The main thing, of course, is that through his own analysis he has become free from vast reservoirs of unconscious hate belonging to the past and to inner conflicts. There are other reasons why hate remains unexpressed and even unfelt as such:

(1) Analysis is my chosen job, the way I feel I will best deal with my own guilt, the way I can express myself in a constructive way.

- (2) I get paid, or I am in training to gain a place in society by psycho-analytic work.
- (3) I am discovering things.
- (4) I get immediate rewards through identification with the patient, who is making progress, and I can see still greater rewards some way ahead, after the end of the treatment.
- (5) Moreover, as an analyst I have ways of expressing hate. Hate is expressed by the existence of the end of the "hour." (pp. 70–71)

I was especially interested in Winnicott's work because the intensity of my reaction, and the way it took me over, was so reminiscent of self-state activity in me, and a multiple self-state model of mind applies to all of us, therapists included. Winnicott did not disappoint, but it occurred in a way that both surprised and then delighted me. In writing about the motives imputed by the patient to the analyst, he offered: "Would it not follow that if a *psychotic* is in a 'coincident love-hate' state of feeling he experiences a deep conviction that the analyst is also only capable of the same crude and dangerous state of coincident love-hate relationship? Should the analyst show love he will surely at the same moment kill the patient" (Winnicott, 1949). I agree with Winnicott that if we are to be the analysts of psychotic patients, then we would need to reach down to very primitive things inside ourselves. But what I didn't expect was his discussion of a healing dream and his description of his psychotic patient that told me he and I were working in the same clinical territory—dissociative processes, not psychosis.

For the sake of brevity, I will report only the second half of Winnicott's dream: "What I knew was that I had no right side of my body at all. This was not a castration dream. It was a sense of not having that part of the body" (Winnicott, 1949, p. 71). The surprise was when he reported his psychotic patient "was requiring of me that I have no relation to her body at all, not even an imaginative one; there was no body that she recognized as hers and if she existed at all she could only feel herself to be a mind." He went on to indicate that the side of his body that faced the patient was his right side.

By chance, some years ago I was invited to discuss a paper by a brilliant disciple of Winnicott, Nina Farhi, who had taught Winnicottian theory for at least 30 years (Chefet, 2008). Farhi, following Winnicott, presented the case of a psychotic woman. Upon reading the exquisitely detailed protocol, I was taken by the descriptions there in the same way I found Winnicott's dream language clearly pointing to experiences of depersonalization, both

in his patient and in his countertransference dream. In my discussion of Farhi's work, I challenged the notion of psychosis and opined that the patient was suffering from a dissociative disorder with profound depersonalization described by having holes in her body that "birds could fly through." In her discussion, challenged by me, she nevertheless agreed with my position. She held Winnicott's perception of the particular case of her patient's depersonalization as psychosis.

I am struck by the extent to which Winnicott was describing a case of hate in the countertransference in a patient with depersonalization, in relation to which he had a healing dream, and the potential for a similar process in my experience of countertransference humiliation. My healing dream alerted me to an oddness: At a gut level I felt good about myself, but on another level, unfamiliar to me, I nevertheless believed I was a monster. (I had a multiple self-state dream in the same way Winnicott had a depersonalization dream.) How did that happen? Why did I believe that?

If somebody loves you and attacks you, then that is deeply wounding and confusing. The only way to understand this is to assume that the attack is because of necessity: I'm attacked because I'm bad, and the attack is needed to protect others from my badness. In the mind of the child, this is about self-hatred; the feeling of being betrayed by my essence and hating that I'm bad and stuck with that. There's also the problem the child has in noticing that they may behave in other ways that are routinely applauded by others. However, there is a lingering fear that others will discover the essential badness that is hidden behind the outward goodness. The child lives in fear of being truly known and then found to be bad—a fate that destroys the felt experience of others loving them.

To be found out creates a horrible sense of foreboding and a wish to remain hidden. The alien self must be hidden lest others discover the badness within. A fear of humiliation makes sense, and an intolerance of feeling anger, rage, contempt, or hatred puts the clinician at risk of isolating these feelings, while still a child. When this happens, the stage is set for enactment of the dissociatively organized emotional set in both patient and therapist (Bromberg, 2003). The monster in me didn't make sense, finally, and I was alert to him. With my monster out of the closet, I was no longer fearful of humiliation—no longer in need of not knowing my anger, rage, contempt, hatred, and other unwelcome feelings. Monsters are people too, and sometimes they are just scared children (Mayer, 1976).

Humiliation Is Distinct From Its Sister, Shame

The setting for the intensive psychotherapy for persistent dissociative processes, including PTSD and complex PTSD as well as the dissociative disorders, must include a place at the table for humiliation, that is, the intent to shame, degrade, damage, and leave a person believing they are defective and beyond repair or redemption, perhaps also corrupted and no longer containing goodness in any way. Sadistic abuse, in my clinical observation, is often about destroying the will to live, extinguishing the urge to fight back for survival and destroying any goodness in the victim. The sadist revels in the felt collapse of the other's mind, their will, so long as their victim is conscious of that collapse and the sadist can see it in the eyes of the victim. While most of my patients were not abused in this way, the mindless ways in which they were regarded as of no consequence, ignored as if having no value, and intentionally made to know their place at the margins of the world, wounded, damaged, and discarded, left deep scars in their minds and often on their bodies.

Speaking the narrative truth about a person's life may not be pretty, but by the time it's tolerable to do that, knowing the details of their experience, and still having my deep respect and commitment to their life and protection of their dignity can be sustaining. Yes, it's about loving and being loved in the way us humans do. But there are model scenes (Lichtenberg, 1989) in which love is not just a four-letter word (Perlin & Lynch, 2015). This is when we must rise to the occasion of defending the potential to put real love to work, and not let the perversions of love into hate and the control and destruction of other people's lives prevail. Knowing the scarred and bloodied underbelly of shame—humiliation—is important if we are to help people to emerge from the traps of their earlier lives when they seek a witness and a guide out of the primal forests in which they are often still imprisoned. It's not a pleasure, but that's never been the intent. At best it is sometimes deeply sobering. It is about showing up for somebody, often after everybody else has gone home. It's about having company on the journey, even if there are times when all you can do is sit together, exhausted but still alive, committed to going farther, and as far as necessary, until it's possible to move again.

References

- Balint, M. (1952). On love and hate. *International Journal of Psycho-Analysis*, 33, 355–362.
- Beebe, B., Messinger, D., Bahrack, L. E., Margolis, A., Buck, K. A., & Chen, H. (2016). A systems view of mother-infant face-to-face communication. *Developmental Psychology*, 52(4), 556–571.
- Bromberg, P. M. (1998). *Standing in the spaces*. Hillsdale, NJ: Analytic Press.
- Bromberg, P. M. (2003). One need not be a house to be haunted: On enactment, dissociation, and the dread of “Not-me.” *Psychoanalytic Dialogues*, 13(5), 689–710.
- Bromberg, P. M. (2006). *Awakening the dreamer: Clinical journeys*. Mahwah, NJ: Analytic Press.
- Bromberg, P. M. (2011). *The shadow of the tsunami and the growth of the relational mind*. New York: Routledge.
- Bucci, W., & Maskit, B. (2007). Dissociation from the perspective of multiple code theory: Part I: Psychological roots and implications for psychoanalytic treatment. *Contemporary Psychoanalysis*, 43(2), 165–184.
- Chefetetz, R. A. (2000). Disorder in the therapist’s view of the self: Working with the person with dissociative identity disorder. *Psychoanalytic Inquiry*, 20(2), 305–329.
- Chefetetz, R. A. (2008). *Nolens volens* out of darkness—from the depersonal to the “really” personal. *Contemporary Psychoanalysis*, 44(1), 18–40.
- Chefetetz, R. A. (2009). Waking the dead therapist. *Psychoanalytic Dialogues*, 19(4), 393–403.
- Chefetetz, R. A. (2015). *Intensive psychotherapy for persistent dissociative processes: The fear of feeling real*. New York: Norton.
- Chefetetz, R. A. (2017). Issues in consultation for treatments with distressed activated abuser/protector self-states in dissociative identity disorder. *Journal of Trauma and Dissociation*, 18(3), 465–475.
- Chefetetz, R. A. (2018). *Attackments: Subjugation, shame, and the attachment to painful affects and objects*. Paper presented at the Shame Matters Conference, Bowlby Centre, London, England.
- Chefetetz, R. A. (2020). Shame and the developmental antecedents of enduring, self-critical mental states: A discussion and some speculations. *Psychiatry*, 83(1), 25–32.
- Demos, E. V. (2019). *The affect theory of Silvan Tomkins for psychoanalysis and psychotherapy: Recasting the essentials*. New York: Routledge.
- Demos, V. (Ed.) (1995). *Exploring affect: The selected writings of Sylvan S. Tomkins*. New York: Cambridge University Press.
- DeYoung, P. A. (2015). *Understanding and treating chronic shame: A relational/neurobiological approach*. New York: Routledge.
- Dorahy, M. J. (2017). Shame as a compromise for humiliation and rage in the internal

- representation of abuse by loved ones: Processes, motivations, and the role of dissociation. *Journal of Trauma and Dissociation*, 18(3), 383–396.
- Elison, J., & Harter, S. (2007). Causes, correlates, and consequences. In J. L. Tracy, R. W. Robins, & J. P. Tangney (Eds.), *The self-conscious emotions: Theory and research* (pp. 310–329). New York: Guilford.
- Fonagy, P., Gergely, G., Jurist, E. J., & Target, M. (2003). *Affect regulation, mentalization and the development of the self*. New York: Other Press.
- Fonagy, P., & Luyten, P. (2009). A developmental, mentalization-based approach to the understanding and treatment of borderline personality disorder. *Development and Psychopathology*, 21(4), 1355–1381.
- Forgash, C., & Knipe, J. (2012). Integrating EMDR and ego state treatment for clients with trauma disorders. *Journal of EMDR Practice and Research*, 6(3), 120–128.
- Freud, S. (1909). Notes upon a case of obsessional neurosis. In J. Strachey (Ed.), *The standard edition* (Vol. 10). London: Hogarth.
- Freud, S. (1917). Mourning and melancholia. In J. Strachey (Ed.), *The standard edition* (Vol. 14, pp. 237–258). London: Hogarth.
- Gallese, V., Eagle, M. N., & Migone, P. (2007). Intentional attunement: Mirror neurons and the neural underpinnings of interpersonal relations. *Journal of the American Psychoanalytic Association*, 55(1), 131–176.
- Gendlin, E. T. (1978). *Focusing*. New York: Bantam.
- Gergely, G., & Watson, J. S. (1996). The social biofeedback theory of parental affect-mirroring: The development of emotional self-awareness and self-control in infancy. *International Journal of Psychoanalysis*, 77, 1181–1211.
- Gilbert, P. (2005). Social mentalities: A biopsychosocial and evolutionary approach to social relationships. In M. W. Baldwin (Ed.), *Interpersonal cognition* (pp. 299–333). New York: Guilford.
- Gorkin, M. (1987). *The uses of countertransference*. Northvale, NJ: Jason Aronson.
- Greenberg, L. S. (2004). Emotion-focused therapy. *Clinical Psychology and Psychotherapy*, 11(1), 3–16.
- Hartling, L. M., Lindner, E., Spalthoff, U., & Britton, M. (2013). Humiliation: A nuclear bomb of emotions? *Psicología Política*, no. 46, 55–76.
- Hartling, L. M., & Luchetta, T. (1999). Humiliation: Assessing the impact of derision, degradation, and debasement. *Journal of Primary Prevention*, 19(4), 259–278.
- Hennighausen, K., & Lyons-Ruth, K. (2005). Disorganization of attachment strategies in infancy and childhood. In R. E. Tremblay, R. G. Barr, & R. D. Peters (Eds.), *Encyclopedia on early childhood development* [online]. Montreal: Centre of Excellence for Early Childhood Development.
- Hicks, D., & Tutu, D. (2011). *Dignity: The essential role it plays in resolving conflict*. New Haven, CT: Yale University Press.
- Johnson, S. E., Hunsley, J., Greenberg, L., & Schindler, D. (1999). Emotion focused

- couples therapy: Status and challenges. *Clinical Psychology: Science and Practice*, 6(1), 67–79.
- Kaufman, G. (2004). *The psychology of shame: Theory and treatment of shame-based syndromes*. New York: Springer.
- Kelly, V. C. (2009). A primer of affect psychology. *The art of intimacy and the hidden challenge of shame*, 158–191.
- Kohut, H. (2009). *The restoration of the self*. Chicago: University of Chicago Press.
- Lacey, D. (2011). The role of humiliation in the Palestinian/Israeli conflict in Gaza. *Psychology and Society*, 4(1), 76–92.
- Lamm, C., & Singer, T. (2010). The role of anterior insular cortex in social emotions. *Brain Structure and Function*, 214(5–6), 579–591.
- Lane, R. D., & Nadel, L. (2000). *Cognitive neuroscience of emotion*. New York: Oxford University Press.
- Lane, R. D., Quinlan, D. M., Schwartz, G. E., & Walker, P. A. (1990). The levels of emotional awareness scale: A cognitive-developmental measure of emotion. *Journal of Personality Assessment*, 55, 124–134.
- Lanius, R. A., Vermetten, E., Loewenstein, R. J., Brand, B., Schmahl, C., Bremner, J. D., & Spiegel, D. (2010). Emotion modulation in PTSD: Clinical and neurobiological evidence for a dissociative subtype. *American Journal of Psychiatry*, 167, 640–647.
- Lansky, M. R. (1992). *Fathers who fail: Shame and psychopathology in the family system*. Hillsdale, NJ: Analytic Press.
- Leask, P. (2013). Losing trust in the world: Humiliation and its consequences. *Psychodynamic Practice*, 19(2), 129–142.
- Ledoux, J. E. (1996). *The emotional brain*. New York: Simon and Schuster.
- Ledoux, J. E. (2012, January 22). Searching the brain for the roots of fear. *New York Times*. <https://opinionator.blogs.nytimes.com/2012/01/22/anatomy-of-fear/>
- LeDoux, J. E., & Pine, D. S. (2016). Using neuroscience to help understand fear and anxiety: A two-system framework. *American Journal of Psychiatry*, 173(11), 1083–1093.
- Levenkron, H. (2006). Love (and hate) with the proper stranger: Affective honesty and enactment. *Psychoanalytic Inquiry*, 26(2), 157–181.
- Levinger, S., Somer, E., & Holden, R. R. (2015). The importance of mental pain and physical dissociation in youth suicidality. *Journal of Trauma and Dissociation*, 16(3), 322–339.
- Lewis, H. B. (1987). *The role of shame in symptom formation*. Hillsdale, NJ: Lawrence Erlbaum.
- Lewis, M. (1992). *Shame: The exposed self*. New York: First Free Press.
- Lichtenberg, J. D. (1989). Model scenes, motivation, and personality. In S. Dowling & A. Rothstein (Eds.), *The significance of infant observational research for clinical work with children, adolescents, and adults* (pp. 91–107). Madison, CT: International University Press.

- Lichtenberg, J. D., Lachmann, F. M., & Fosshage, J. L. (1996). *The clinical exchange: Techniques derived from self and motivational systems*. Hillsdale, NJ: Analytic Press.
- Liotti, G. (2011). Attachment disorganization and the controlling strategies: An illustration of the contributions of attachment theory to developmental psychopathology and to psychotherapy integration. *Journal of Psychotherapy Integration*, 21(3), 232.
- Lyons-Ruth, K., Dutra, L., Schuder, M. R., & Bianchi, I. (2006). From infant attachment disorganization to adult dissociation: Relational adaptations or traumatic experiences? In R. A. Chefetz (Ed.), *Dissociative disorders: An expanding window into the psychobiology of mind* (Vol. 29, pp. 63–86). Philadelphia: Saunders.
- Martel, Y. (2010). *Beatrice and Virgil*. New York: Spiegel and Grau.
- Mayer, M. (1976). *There's a monster in my closet*. New York: Penguin.
- Miller, A. (1981). *The drama of the gifted child*. New York: Basic Books.
- Miller, S. (1985). *The shame experience*. Hillsdale, NJ: Analytic Press.
- Morrison, A. P. (1989). *Shame: The underside of narcissism*. Hillsdale, NJ: Analytic Press.
- Nathanson, D. L. (1992). *Shame and pride: Affect, sex, and the birth of the self*. New York: Norton.
- Ogden, P., Minton, K., & Pain, C. (2006). *Trauma and the body: A sensorimotor approach to psychotherapy*. New York: Norton.
- Paivio, S. C., & Nieuwenhuis, J. A. (2001). Efficacy of emotion focused therapy for adult survivors of child abuse: A preliminary study. *Journal of Traumatic Stress*, 14(1), 115–133.
- Panksepp, J. (1998). *Affective neuroscience: The foundations of human and animal emotions*. New York: Oxford University Press.
- Panksepp, J. (2004). Affective consciousness: Core emotional feelings in animals and humans. *Consciousness and Cognition*, 14(1), 30–80.
- Panksepp, J., & Biven, L. (2012). *The archaeology of mind: Neuroevolutionary origins of human emotions*. New York: Norton.
- Perlin, M. L., & Lynch, A. J. (2015). Love is just a four-letter word: Sexuality, international human rights, and therapeutic jurisprudence. *Canadian Journal of Comparative and Contemporary Law*, 1(1), 9–48.
- Pizzagalli, D. A., Lehmann, D., Hendrick, A. M., Regard, M., Pascual-Marqui, R. D., & Davidson, R. J. (2002). Affective judgments of faces modulate early activity (~160ms) within the fusiform gyri. *Neuroimage*, 16, 663–677.
- Ploghaus, A., Narain, C., Beckmann, C. F., Clare, S., Bantick, S., Wise, R., Matthews, P. M., Nicholas, J., Rawlins, P., & Tracey, I. (2001). Exacerbation of pain by anxiety is associated with activity in a hippocampal network. *Journal of Neuroscience*, 21(December), 9896–9903.
- Ploghaus, A., Tracey, I., Gati, J. S., Clare, S., Menon, R. S., Matthews, P. M., Nicholas, J., & Rawlins, P. (1999). Dissociating pain from its anticipation in the human brain. *Science*, 284(5422), 1979–1981.

- Rainville, P., Duncan, G. H., Price, B. C., & Bushnell, M. C. (1997). Pain affect encoded in human anterior cingulate but not somatosensory cortex. *Science*, 277(August 1997), 968–971.
- Rauch, S., Shin, L. M., & Wright, C. I. (2003). Neuroimaging studies of amygdala function in anxiety disorders. *Annals of the New York Academy of Sciences*, 985, 389–410.
- Rauch, S. L., van der Kolk, B. A., Fisler, R. E., Alpert, N. M., Orr, S. P., Savage, C. R., Fischman, A. J., Jenike, M. A., & Pitman, R. K. (1996). A symptom provocation study of posttraumatic stress disorder using positron emission tomography and script driven imagery. *Archives of General Psychiatry*, 53, 380–387.
- Rothstein, A. (1984). Fear of humiliation. *Journal of the American Psychoanalytic Association*, 32(1), 99–116.
- Ryle, A. (Ed.) (1999). *Cognitive analytic therapy: Developments in theory and practice*. New York: John Wiley.
- Scheff, T. J., & Retzinger, S. M. (2001). *Emotions and violence: Shame and rage in destructive conflicts*. Lincoln, NE: iUniverse.
- Schlumpf, Y. R., Nijenhuis, E. R., Chalavi, S., Weder, E. V., Zimmermann, E., Luechinger, R., Marca, R. L., Reinders, S., & Jäncke, L. (2013). Dissociative part-dependent biopsychosocial reactions to backward masked angry and neutral faces: An fMRI study of dissociative identity disorder. *NeuroImage: Clinical*, 3, 54–64.
- Schore, J. R., & Schore, A. N. (2008). Modern attachment theory: The central role of affect regulation in development and treatment. *Clinical Social Work Journal*, 36, 9–20.
- Searles, H. (1967). The dedicated physician. In R. W. Gibson (Ed.), *Crosscurrents in psychiatry and psychoanalysis* (pp. 128–143). Philadelphia: Lippincott.
- Shapiro, F. (1995). *Eye movement desensitization and reprocessing*. New York: Guilford.
- Shin, L. M., Kosslyn, S. M., McNally, R. J., Alpert, N. M., Thompson, W. L., Rauch, S. L., Macklin, M. L., & Pitman, R. K. (1997). Visual imagery and perception in posttraumatic stress disorder. *Archives of General Psychiatry*, 54, 233–241.
- Shin, L. M., & Liberzon, I. (2010). The neurocircuitry of fear, stress, and anxiety disorders. *Neuropsychopharmacology Reviews*, 35, 169–191.
- Shin, L. M., Rauch, S. L., & Pitman, R. K. (2006). Amygdala, medial prefrontal cortex, and hippocampal function in PTSD. *Annals of the New York Academy of Sciences*, 1071, 67–79.
- Shin, L. M., Wright, C., Cannistraro, P. A., Wedig, M., McMullin, K., Martis, B., Macklin, M., Lasko, N., Cavanagh, S., Krangel, T., Orr, S., Pitman, R., Whalen, P., Rauch, S. L. (2005). A functional magnetic resonance imaging study of amygdala and medial prefrontal cortex responses to overtly presented fearful faces in posttraumatic stress disorder. *Archives of General Psychiatry*, 62, 273–281.
- Sierra, M., Senior, C., Dalton, J., McDonough, M., Bond, A., Phillips, M. L., O'Dwyer, A. M., & David, A. S. (2002). Autonomic response in depersonalization disorder. *Archives of General Psychiatry*, 59, 833–838.

- Spiegel, H., & Spiegel, D. (1978). *Trance and treatment: Clinical uses of hypnosis*. Washington, DC: American Psychiatric Press.
- Stern, D. B. (2010). *Partners in thought: Working with unformulated experience, dissociation, and enactment*. New York: Routledge.
- Tangney, J. P., & Dearing, R. L. (2003). *Shame and guilt*. New York: Guilford.
- Tangney, J. P., Miller, R. S., Flicker, L., & Barlow, D. H. (1996). Are shame, guilt, and embarrassment distinct emotions? *Journal of Personality and Social Psychology*, 70(6), 1256.
- Taylor, G. J. (2000). Recent developments in alexithymia theory and research. *Canadian Journal of Psychiatry*, 45(2), 134–142.
- Tomkins, S. S. (1962). *Affect imagery consciousness: Vol. 1. The positive affects*. New York: Springer.
- Tomkins, S. S. (1963). *Affect imagery consciousness: Vol. 2. The negative affects*. New York: Springer.
- Tomkins, S. S. (1982). *Affect, imagery, consciousness: Vol. 3. Cognition and affect*. New York: Springer.
- Tomkins, S. S. (1995). Script theory. In E. V. Demos (Ed.), *Exploring affect: The selected writings of Silvan S. Tomkins* (pp. 312–388). New York: Cambridge University Press.
- Tomkins, S. S., & Karon, B. P. (1962). *Affect, imagery, consciousness: Vol. 4. Cognition*. Cambridge, UK: Gaunt.
- Tomkins, S. S., & McCarter, R. (1995). What and where are the primary affects? Some evidence for a theory. In E. V. Demos (Ed.), *Exploring affect: The selected writings of Silvan S. Tomkins* (pp. 217–262). New York: Cambridge University Press.
- Torres, W. J., & Bergner, R. M. (2010). Humiliation: Its nature and consequences. *Journal of the American Academy of Psychiatry and the Law Online*, 38(2), 195–204.
- Trumbull, D. (2003). Shame: An acute stress response to interpersonal traumatization. *Psychiatry*, 66(1), 53–64.
- Watkins, J. G. (1971). The affect bridge: A hypnoanalytic technique. *International Journal of Clinical and Experimental Hypnosis*, 19, 21–27.
- Widen, S. C., & Russell, J. A. (2010). The “disgust face” conveys anger to children. *Emotion*, 10(4), 455–466.
- Winnicott, D. W. (1949). Hate in the countertransference. *International Journal of Psychoanalysis*, 30, 69–75.
- Wolf, E. S. (1988). *Treating the self: Elements of clinical self psychology*. New York: Guilford.
- Wurmser, L. (2000). *The power of the inner judge: Psychodynamic treatment of the severe neuroses*. Northvale, NJ: Jason Aronson.